MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01068

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: DELAWARE County: SUSSEX
City or town: CONCORD
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mr. Elizah Baker (ELIJAH WALTER BAKER)

3.(b) Social Security Number: 221-05-6434

4. Sex: Male
5. Color or race: W
6.(a) Single, married, widowed, or divorced: ✓ MARRIED
6.(b) Name of husband or wife: MARY JANE HILL
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): MAY 6, 1881
8. AGE: Years: 64 Months: 8 Days: 5 If less than one day: hrs. min.
9. Birthplace: PITTSVILLE, MARYLAND (Town, county, and state)
10. Usual occupation: CARPENTER
11. Industry or business: Wm F. BAKER
FATHER 12. Name: BEARD BAKER
13. Birthplace: UNKNOWN
MOTHER 14. Maiden name: ADLINE LEWIS
15. Birthplace: UNKNOWN
16. Informant: MARY JANE BAKER (WIFE)
Address: CONCORD, DELAWARE
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: JAN. 16, 1946 (month) (day) (year)
Cemetery or crematory: CONCORD CEMETERY
Location: CONCORD, DELAWARE
18. Funeral director: M. L. Watson Jr.
Address: SEAFORD, DELAWARE
19. 1/12, 19 46 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 - 11 19 46 at 12 40 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death	DURATION
Fractured Cervical Vertebrae	24 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 1/11/46
Where did injury occur? near Seaford (City or town) Sussex (County) Del (State)
Injured at home, farm, industry, public place (where?): Work on house
Means of injury: Fell from scaffold Injured at work? Yes

23. SIGNATURE: J. A. Bodenhamer M.D. Deputy Med. Exam. Wicomico Co. M. D. or other
Address: Salisbury, Md. Date signed: 1/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01069

Reg. Dist. No. 327

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Nanticoke

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Arvilla F. Barclay

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	married

6.(b) Name of husband or wife Hampton Barclay

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Don't Know 1882

8. AGE: Years	Months	Days	If less than one day
64	?	?	hrs. min.

9. Birthplace Nanticoke, Wicomico Co, Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Jones

13. Birthplace Nanticoke, Md.

MOTHER 14. Maiden name Lillie Long

15. Birthplace Nanticoke, Md.

16. Informant Hampton Barclay

Address Nanticoke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1946 (month) (day) (year)

Cemetery or crematory Cemetery, Nanticoke

Location near Jesters' store

18. Funeral director C. A. Messick

Address Bivalve Md

19. Jan 21 1946 (Date rec'd by registrar) C. Woolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 19 1946, at 5:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19 to [illegible] 19

and that I last saw h[illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Coronary Thrombosis	sudden death
Due to	
Due to	
Other conditions Chronic myocarditis	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Addison Lankford M.D. Deputy Med Exam M. D. or other

Address Salisbury Md Date signed 1/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

01610

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Mantiecake
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Mantiecake
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Merella Lucille Barkley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 1 1929

8. AGE:

Years	Months	Days	If less than one day
16	6	6	..... hrs. ..... min.

9. Birthplace: Mantiecake Md
(Town, county, and state)

10. Usual occupation: School Child

11. Industry or business

FATHER
12. Name: Monroe Barkley
13. Birthplace: Mantiecake Md

MOTHER
14. Maiden name: Lena Jones
15. Birthplace: Cheriton Va.

16. Informant: Monroe Barkley
Address: Mantiecake Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1946 (month) (day) (year)

Cemetery or crematory: Mantiecake

Location: Near Jester's Store

18. Funeral director: C. Bell Smith

Address: Bivalve Md

19. Jan 9 1946 (Date rec'd by registrar) R. Wilford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7 1946, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30 1945 to Jan 6 1946 and that I last saw her alive on Jan 6 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	6 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: S. Allen Tull M. D. or other

Address: Mantiecake, Md Date signed: 1/8/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01011

FILM No. I 00 FEB 14 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 233

1. PLACE OF DEATH:

County: Worcester

City or town: Parsonsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Eliza Ann Blake

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Black	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 30 - 1847

8. AGE: Years	Months	Days	If less than one day
98 99-	0	3	hrs. min.

9. Birthplace: Powellsville (Town, county, and state) Md

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace

MOTHER 14. Maiden name: unknown

15. Birthplace

16. Informant: Hennietta Parsons

Address: Parsonsburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5-1946 (month) (day) (year)

Cemetery or crematory: Glas Hill

Location: near Parsonsburg Md.

18. Funeral director: Wm. Howard Veld.

Address: Pittsville. Md.

19. 1/3/1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 2nd 1946 at 2 0/4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Arterio sclerotic heart disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred L. Grapue M.D. M. D. or other

Address: Salisbury Md. Date signed: 2-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

01 12

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years
Hospital, institution, or street address where death occurred:
P. H. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 E. Locust Street
(If rural, give LOCATION)
2.(a) If veteran, name war World War #1

3.(a) FULL NAME Elmer Raymond Biddell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife Elsie M. Biddell
B.(c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) May 4 - 1893

8. AGE: Years	Months	Days	If less than one day
52	8	4	...hrs. ...min.

9. Birthplace Cape Charles Virginia (Town, county, and state)
10. Usual occupation Police Officer
11. Industry or business Salisbury Police Force
FATHER 12. Name Elmond C. Biddell
FATHER 13. Birthplace Powellville Md.
MOTHER 14. Maiden name Blanche Powell
MOTHER 15. Birthplace Near Princess Anne Md
16. Informant Mrs. Elsie M. Biddell
Address 102 E. Locust, St. Salisbury Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 11-46 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland
18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Md.
19. 1/11/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 46 at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Jan 8 1946
and that I last saw h...l... alive on Jan 8 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Salisbury Md. Date signed 1/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

01013

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 Years

Hospital, Institution, or street address where death occurred:
400 South Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 400 South Division St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Annie Chatham

3.(b) Social Security Number 214-10-7387

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James S. Chatham

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): March, 30, 1877

8. AGE: Years	Months	Days	If less than one day
68	9	20	..... hrs. ..... min.

9. Birthplace: Wicomico Co. Md
(Town, county, and state)

10. Usual occupation: Housewife & Inspector

11. Industry or business: Shirt Factory

FATHER
12. Name: William Sullivan
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Mary Livington
15. Birthplace: Wicomico Co. Md

16. Informant: James Chatham
Address: Salisbury, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 1 / 22 / 46
(month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 1/22/46 1946 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 19, 1946, 11 15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 17 1946 to Jan 19 1946 and that I last saw h[illegible] alive on Jan 19 1946

Immediate cause of death	DURATION
Cardiorespiratory arrest	1 hr
Due to Diabetis Mellitus	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other

Address: Salisbury Md Date signed: Jan 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
FEB 11 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01014

CERTIFICATE OF DEATH

Reg. Diat. No. 331

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md County: Wicomico

City or town: Quantico

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME Littleton P. Church

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a.a.	married

6.(b) Name of husband or wife: Sarah Church

8.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1889

8. AGE: Years	Months	Days	If less than one day
about 57	—	—	....hrs. ....min.

9. Birthplace: Quantico md (Town, county, and state)

10. Usual occupation: Minister

11. Industry or business: Sailor

FATHER 12. Name: James Church

13. Birthplace: Quantico md

MOTHER 14. Maiden name: Lalie Gaskill

15. Birthplace: Quantico md

16. Informant: Mrs Ruth Gale

Address: Quantico md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23-1946 (month) (day) (year)

Cemetery or crematory: Quantico

Location: Quantico

18. Funeral director: James H. Stewart

Address: Salisbury md

19. July 23 1946 (Date rec'd by registrar) Mrs J. M. Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19 1946, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9 1946, to January 19 1946 and that I last saw h.im alive on January 19 1946

Immediate cause of death	DURATION
Apoplexy	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of ....

Where did injury occur? ....(City or town) ....(County) ....(State)

Injured at home, farm, industry, public place (where?) ....

Means of injury: ....Injured at work?

23. SIGNATURE: D Allen Fields M. D. or other

Address: Salisbury, md Date signed: 7/23/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Redmond

01015

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 329

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Charlestown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Cornell, Mr. John.

3.(b) Social Security Number

4. Sex: M | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary B. Cornell | 6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): May 25 1875

8. AGE: Years: 70 | Months: 7 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: New Moscow Ohio (town, county and state)

10. Usual occupation: Retired RR agent

11. Industry or business:

FATHER — 12. Name: Thomas H. Cornell

13. Birthplace: Ohio

MOTHER — 14. Maiden name: Lillis Bowen

15. Birthplace: Ohio.

16. Informant: Rowley B. Cornell

Address: 1646 Newton N.W. Washington

17. Burial (Burial, cremation, or removal; Which?) Date thereof: 1 - 5 - 1946 (month) (day) (year)

Cemetery or crematory: Firemans

Location: Charlestown

18. Funeral director: Edwin Boos

Address: Charlestown, Md.

19. 1/6 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 1946, at 848 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1945, to Jan 2 1946, and that I last saw h.. alive on Jan 2 1946

Immediate cause of death	DURATION
Left Pyelonephrosis	21 days
Due to	
Due to	
Other conditions: Ruptured duodenal ulcer	10 days
acute cholecystitis	10 days

(Include pregnancy within 3 months of death)

Major findings of operations: Perforated ulcer duodenal acute cholecystitis Date of op. Jan 20, 1946

Autopsy results: Left Pyelonephrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Salisbury Md Date signed 1/2/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01616

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months
Hospital, institution, or street address where death occurred: 612 Park Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: 612 Park Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mattie Ann Dodd

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Asahel R. Dodd
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Oct. 14 1869

8. AGE: Years	Months	Days	If less than one day
76	3	2	hrs. min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation:
11. Industry or business: at Home

FATHER
12. Name: James Dayton
13. Birthplace: Hammonton N.J.

MOTHER
14. Maiden name: Millin
15. Birthplace: N.J.

16. Informant: Mrs. Katherine Bowing
Address: 612 Park ave. Salisbury Md

17. Burial, cremation, or removal. Which? Buried Date thereof (month) (day) (year) Jan. 15-46
Cemetery or crematory: Millsboro Cem.
Location: Millsboro Delaware

18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Maryland

19. (Date rec'd by registrar) 1/16/1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1946 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 12 1946, to Jan. 12 1946
and that I last saw h alive on Jan. 12 1946

	DURATION
Immediate cause of death: Chronic myocarditis	2-4 yrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harmon M.D.
M. D. or other
Address: Salisbury Md. Date signed: Jan. 14

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01017

★ Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William H. Dolbey

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Emma Dolbey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 27, 1860

8. AGE: Years	Months	Days	If less than one day
85	6	12	..... hrs. ..... min.

9. Birthplace White Haven Md.
(Town, county, and state)

10. Usual occupation Miller

11. Industry or business Flour Mill

FATHER 12. Name Stephen W. Dolbey

FATHER 13. Birthplace White Haven Md.

MOTHER 14. Maiden name Henrietta Simpkins

MOTHER 15. Birthplace Mt Vernon, Md.

16. Informant Miss Mildred Dolbey

Address White Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 10 1946 (month) (day) (year)

Cemetery or crematory Dolbey Cemetery

Location White Haven, Md.

18. Funeral director Dale Dashiell

Address Princess Anne, Md.

19. Jan. 10 1946 (Date rec'd by registrar) L. Wolford Matter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1946, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5 1946, to January 8 1946

and that I last saw h... alive on January 5, 1946

Immediate cause of death Coronary Thrombosis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Allen Fuels M. D. or other

Address Salisbury, Md. Date signed 1-9-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13a)

CERTIFICATE OF DEATH

01018

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: In Village
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. In Village (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Olevia Catherine Driscoll

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 1-1879

8. AGE: Years 72 | Months — | Days 17 | If less than one day: hrs. ..... min.

9. Birthplace: R.D. Pittsville Md (Town, county, and state)

10. Usual occupation: at Home

11. Industry or business

FATHER
12. Name: John L. Driscoll
13. Birthplace: Wico. Co. near Salisbury Md

MOTHER
14. Maiden name: Mary Jane Deming
15. Birthplace: Worcester Co. Md

16. Informant: Mrs. Margie M. Adkins
Address: RD #1 Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 20-46 (month) (day) (year)
Cemetery or crematory: Driscoll Cem.
Location: near Powellville Md.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 1/20/46 (Date rec'd by registrar) 19.46. Laurie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18th 19.46 at 1.15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 19.46 to Jan 18th 19.46 and that I last saw her alive on Jan 17 19.46

Immediate cause of death	DURATION
Cardiac decomp.	
Due to Arteriosclerotic C-V-R Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: Jno D Holloway M.D. M. D. or other
Address: Salisbury Md Date signed: Jan 18 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Del. County: Sussex

City or town: Laurel R.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elliott Baby Donald Edward

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife

B.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan 2 1946

8. AGE:

Years	Months	Days	If less than one day
0	0	1	hrs. ... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Laurence Elliott

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Verdie E. Elliott

MOTHER — 15. Birthplace: Delaware

16. Informant: Laurence Elliott

Address: Laurel Del

17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 4 46 (month) (day) (year)

Cemetery or crematory: Laurel Memorial Cemetery

Location: Laurel Delaware

18. Funeral director: J. Harry Williams

Address: Delmar Md.

19. (Date rec'd by registrar) 1/4 1946 Registrar: Ward E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 3 1946, at 5-45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Due to: Heart Block	July
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: ... M. D. or other

Address ... Date signed ...

Reported by. A.N.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-b)

CERTIFICATE OF DEATH

01020

Reg. Diat. No. 331

1. PLACE OF DEATH:
County Wicomico
City or town Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Isaac Raymond Elliott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W.	Married

6.(b) Name of husband or wife Nannie Elliott
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 30, 1898

8. AGE: Years	Months	Days	If less than one day
47	11	15	hrs. min.

9. Birthplace Salisbury Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation Merchant
11. Industry or business General Merchandise
FATHER 12. Name J. D. Elliott
13. Birthplace Salisbury Md.
MOTHER 14. Maiden name Mary Tilgman
15. Birthplace Salisbury Md.
16. Informant Mrs. Raymond Elliott
Address Hebron, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/46 (month) (day) (year)
Cemetery or crematory Parsley Cemetery
Location Parsley Md.
18. Funeral director David L. Megueck
Address Hebron Md.
19. Jan 16 1946 Mrs J M Wallace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1946 at 4 o'clock A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 1945 to January 13 1946
and that I last saw him alive on January 13 1946
Immediate cause of death Pulmonary Tuberculosis — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other
Address Hebron Md. Date signed Jan. 16, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01021

Reg. Diat. No. 4336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 66 years

Hospital, Institution, or street address where death occurred:
104 State Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 104 State
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Elliott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm.Burton Elliottt

6.(c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Nov. 24,1860

8. AGE:	Years	Months	Days	If less than one day
	85			hrs. min.

9. Birthplace Sussex County, Delaware
(Town, county, and state)

10. Usual occupation House work

11. Industry or business Home

FATHER
12. Name Geo. W.German
13. Birthplace Sussex County, Del.

MOTHER
14. Maiden name Matilda Hastings
15. Birthplace Sussex County, Delaware

16. Informant William Burton Elliott
Address Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan-8,1945 (month) (day) (year)

Cemetery or crematory XXXXX M.E.

Location Delmar, Delaware

18. Funeral director W. S. Mansel Co

Address Delmar Delaware

19. Jan 7th 1945 (Date rec'd by registrar) Harry E Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1946, at 7.20P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 5 1946 and that I last saw her alive on Jan 3 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
with general paralysis	
Due to Arterio Sclerosis	8 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.B.Lynch M. D. or other

Address Delmar Del Date signed June 6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01122 233

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, institution or street address where death occurred: 415 Dana street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 415 Dana St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Julia Emma Ennis

3. (b) Social Security Number:

4. Sex: female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Thomas Ennis
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Nov. 10 1851

8. AGE: Years: 94 Months: 1 Days: 21 If less than one day: hrs. min.

9. Birthplace: P.O. Salisbury Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business: At Home

FATHER
12. Name: Adkins
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Brumley
15. Birthplace: Wicomico Co. Md.

16. Informant: Mr. Herbert Sturgis
Address: Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 4-1946 (month) (day) (year)
Cemetery or crematory: Powell Cem.
Location: near Powellville Md.

18. Funeral director: Holloway & G. Walter H. Holloway
Address: Salisbury Maryland.

19. (Date rec'd by registrar) 1/4 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12 1946 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1945 to Jan 1 1946
and that I last saw h... alive on Dec 31, 1945

	DURATION
Immediate cause of death: Cardio Vascular	
Due to: Senesc	10 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underlioe the canse to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S Allen Dulda M. D. or other
Address: Salisbury Md. Date signed: 1-2-46

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

01023

Reg. Dist. No. 353

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Twenty three years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 207 Delaware
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Annie Thomas Gayle

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a a	married

6.(b) Name of husband or wife: Samuel Gayle

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.): about 1875

8. AGE: Years: about 71 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Quantico
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER
12. Name: William Gayle
13. Birthplace: Quantico md

MOTHER
14. Maiden name: Henrietta White
15. Birthplace: Dames Quarter md

16. Informant: Samuel Gayle
Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3. 1946 (month) (day) (year)

Cemetery or crematory: Quantico md

Location: Quantico md

18. Funeral director: James R. Stewart

Address: Salisbury md

19. 2/3/46 (Date rec'd by registrar) [illegible] E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-31 19 46 at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-15 19 45 to 1-30 19 46

and that I last saw h[illegible] alive on 1-30- 19 46

Immediate cause of death: Asphyxia, Organic. Natural sequence of cardiac asthma 3 one day. — DURATION

Due to: Cardiac Asthma.

Due to: Myocardial damage

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: E. A. Purnell, M.D.
M. D. or other

Address: 230 W. Main St. Salisbury Date signed: 2-1-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Grauer.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01024

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emmanuel Episcopal Hospital

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME [redacted] John Samuel Gordy

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	✓

6.(b) Name of husband or wife Mrs. Vernam Gordy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 22 nd 1915

8. AGE: Years 30 | Months 7 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Maryland (Town, county, and state)

10. Usual occupation Auto Mechanic

11. Industry / Business U.S. Rubber Co.

FATHER 12. Name William Burton Gordy

FATHER 13. Birthplace P.O. Delmar Md.

MOTHER 14. Maiden name Grace Elizabeth Jones

MOTHER 15. Birthplace Fruitland Md.

16. Informant Mr. W. Burton Gordy

Address Fruitland Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 31 1946 (month) (day) (year)

Cemetery or crematory Fruitland Cem.

Location Fruitland Md.

18. Funeral director Holloway & Co. Walter R. Holloway

Address Salisbury Md.

19. 1/31/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 28 19 46 at 7 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Myocardiosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Fred R. Grauer M.D. M. D. or Other

Address ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01025

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 7/21/45
Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sana.
How long in hospital or institution? Since 7/21/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Fruitland Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Griffin, Laura Ennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William J. Griffin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 15, 1875

8. AGE: Years	Months	Days	If less than one day
70	4	18	..... hrs. ..... min.

9. Birthplace: Worcester County Maryland
(Town, county, and state)
10. Usual occupation: Canning Factory
11. Industry or business
FATHER 12. Name: James S. Ennis
13. Birthplace: Worcester County Maryland
MOTHER 14. Maiden name: Mary Dennis
15. Birthplace: Berlin Maryland
16. Informant: Mr. William Griffin
Address: McCord Bldg. Elkton, Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 6-46 (month) (day) (year)
Cemetery or crematory: Smullen Fam
Location: Worcester Co. Maryland
18. Funeral director: Holloway & Walter A. Holloway
Address: Salisbury Maryland
19. 1/6, 19 46, Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3, 19 46, at 11:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21, 19 45, to 1/3/46, 19 ..... and that I last saw her alive on January 3, 19 46
Immediate cause of death ..... DURATION
Pulmonary Tuberculosis — 20 mo.
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Paul Cohen, M. D. or other
Address: Snow Hill, Maryland Date signed 1/4/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of year of birth of deceased is shown on FILM No. 100 FEB 14 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01026 Reg. Dist. No. 11 336

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)
Street No.: 4 Railroad Avenue (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Oscar Cleveland Hancock

3.(b) Social Security Number: 221-07-2334

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Beulah Hancock
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Dec 6 1890 1889

8. AGE: Years: 56 Months: Days: If less than one day: hrs. min.

9. Birthplace: New Church, Va. (Town, county, and state)
10. Usual occupation: Sawyer
11. Industry or business

FATHER
12. Name: Sidney Hancock
13. Birthplace: Pocomoke City, Md

MOTHER
14. Maiden name: Sallie Jones
15. Birthplace: Pocomoke City, Md.

16. Informant: Mrs Oscar Hancock
Address: Delmar, Del.

17. Buried (Burial, ~~cremation, or removal~~ Which?) Date thereof 1-9-46 (month) (day) (year)
Cemetery or crematory: M. P.
Location: Delmar, Delaware
18. Funeral director: W. S. Grant Co
Address: Delmar, Delaware

19. Jan 7, 1946 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6th 1946, at 5.45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 25 1945 to Jan 6 1946
and that I last saw him alive on Jan 6 1946

Immediate cause of death	DURATION
Acute dilatation of heart	few hours
Due to Chronic Myocarditis & cardiac Sclerosis	3 yrs
Due to Acute influenza	2 weeks
Other conditions Ague & cold	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J H Tyndall M. D. or other
Address: Delmar Del. Date signed: Jan 7 46

VS A15 9-45-1

(H) MARGIN RESERVED FOR BINDING

(T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01027

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 393

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Rural 2
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Years

Hospital, Institution, or street address where death occurred:

At Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Rural 2
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida Ellen Hill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Joseph C. Hill

6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1867

8. AGE: Years	Months	Days	If less than one day
78	3	6	hrs. min.

9. Birthplace Wicomico Co. Md
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Huston Robinson

13. Birthplace Dorcester, Co. Md

MOTHER 14. Maiden name Suson Sherman

15. Birthplace Dorcester, Co. Md

16. Informant Fred T. Hill

Address Salisbury, Md

17. Burial Date thereof 1 / 25 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md

19. 1/25/46 H. Garnett E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 23 1946 at 10 15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Jan 1946 and that I last saw h alive on Jan 14 1946

	DURATION
Immediate cause of death Coronary Thrombosis	
Due to Arteriosclerotic C-V Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Garnett E. Johnson M. D., or other

Address Salisbury Md Date signed Jan 25, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01628

Reg. Dist. No. 2-33

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 years
Hospital, Institution, or street address where death occurred: R.D. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Hoffman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Ferdinand or Fred Hoffman
B.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Feb. 28-1858

8. AGE: Years: 87 | Months: 10 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Switzerland (town, county, and state)
10. Usual occupation:
11. Industry or business: at Home

FATHER
12. Name: Fluechinger
13. Birthplace: Switzerland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Switzerland

16. Informant: Mrs. Mary J. Hoffman
Address: Indian Head, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 26-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter P. Holloway
Address: Salisbury Maryland

19. 1/24/46 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23rd 1946 at 6-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1946 to Jan 23 1946 and that I last saw h[illegible] alive on Jan 23 1946

Immediate cause of death	DURATION
Chronic myocarditis	3 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Lawrence M.D. M. D. or other
Address: Salisbury Md. Date signed: Jan. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on Dr. Manual

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

FILM No. I 00 FEB 14 1946

CERTIFICATE OF DEATH

01029

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 Yrs

Hospital, Institution, or street address where death occurred: P.G. Hospital

How long in hospital or institution? 15 Yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Pittsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jane Harman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Married

6.(b) Name of husband or wife: William J Harman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 7 1888

8. AGE: Years	Months	Days	If less than one day
57	8	7	hrs. min.

9. Birthplace: Pittsville Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Leo Harman

13. Birthplace: Pittsville Md

MOTHER — 14. Maiden name: Mary Hester Harman

15. Birthplace: Pittsville Md

16. Informant: Catherine Parks

Address: Pittsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17 1946 (month) (day) (year)

Cemetery or crematory: Pittsville M.E. Church

Location: Pittsville Cemetery

18. Funeral director: L.G. Messick

Address: Pittsville Md

19. 1/17/46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 14 19 46 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 to Jan 14 19 46

and that I last saw h alive on Jan 14 19

Immediate cause of death: Coronary Thrombosis — DURATION: 1 day

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J Harriman M. D. M. D. or other

Address: Pittsville Md Date signed Jan 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01030

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela, Rural (Athol)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Ellisetts, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Wesley James

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Martha A. Willey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 7, 1859

8. AGE: Years	Months	Days	If less than one day
86	10	21	..... hrs. ..... min.

9. Birthplace: Ellisetts, Dorchester, Md.
(Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business

FATHER
12. Name: William James
13. Birthplace: Dorchester Co. Md.

MOTHER
14. Maiden name: Emily J. Moore
15. Birthplace: Dorchester Co. Md.

16. Informant: Granville C. James
Address: Mardela Md. R.D. (Rural)

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/46 (month) (day) (year)
Cemetery or crematory: Mardela Cem.
Location: Mardela Md.

18. Funeral director: David H. Messick
Address: Hebron Md.

19. 1/30/46 19..... W. H. Robertson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28, 1946, at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 26 1946, to Jan. 29 1946, and that I last saw h.. alive on Jan. 27 1946

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Hebron Md. Date signed Jan. 29-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01631

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Dusk

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Richard James

3.(b) Social Security Number: 219-07-6976

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	A.A.	Married-Widower

6.(b) Name of husband or wife: Estranel Hazelett

Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Apr 21 1886

8. AGE:

Years	Months	Days	If less than one day
59	8	29	hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER

12. Name: Moses James

13. Birthplace: Salisbury md

MOTHER

14. Maiden name: Melitia Blake

15. Birthplace: Salisbury md

16. Informant: Emma Russell

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28-1946 (month) (day) (year)

Cemetery or crematory: Houston

Location: Salisbury md

18. Funeral director: James H. Stewart

Address: Salisbury md

19. 1/28/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-24 19 46, at 10 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 45, to 1-24 19 46

and that I last saw h. l. m. alive on 1-21-46. 19

Immediate cause of death	DURATION
Uremia	
Due to: Cardiovascular renal disease.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Luther A. Linthicum M. D. or other

Address: Salisbury Md Date signed 1-24-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

01632

Reg. Dist. No. 999

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred 546 S. Division Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 546 S. Division St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Burton Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Minerva E. Jones
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) March 3 1867

8. AGE: Years	Months	Days	If less than one day
78	10	9	hrs. min.

9. Birthplace P.O. #1, Salisbury Md
(Town, county, and state)
10. Usual occupation retired
11. Industry or business Farmer

FATHER
12. Name William Jones
13. Birthplace Accomac Co. Va.

MOTHER
14. Maiden name Maria Pickett
15. Birthplace Accomac. Va.

16. Informant Mrs. Ida Jones
Address 546 S. Div St. Salisbury Md

17. Burial (Burial, cremation, or removal) Date thereof Jan. 15-1946 (Month) (day) (Year)
Cemetery or crematory Parsons Funeral Home
Location P.O. #1 Salisbury Md.
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Maryland

19. 1/15 1946 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 12 1946 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 to Jan 12 1946
and that I last saw h alive on Jan 12 1946

Immediate cause of death	DURATION
Cerebral Embolism	Sudden
Due to Coronary Thrombosis	death
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 1/12
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Injured at work?

23. SIGNATURE Pat Rademaker, MD Deputy Health Officer M. D. or other
Address Salisbury, Md Date signed 1/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01033

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.G. Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. Box 121
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Francis Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Nora a. Jones
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Oct. 18-1909

8. AGE: Years	Months	Days	If less than one day
36	3	1	hrs. min.

9. Birthplace: R.D. #4 Salisbury Md (Town, county, and state)
10. Usual occupation: Owner & operator of
11. Industry or business: service station

FATHER
12. Name: Alfred Thomas Jones
13. Birthplace: R.D. #4 Salisbury Md.

MOTHER
14. Maiden name: Martha Ellen Fessington
15. Birthplace: R.D. #1, ~~Salisbury~~ Md (Fruitland)

16. Informant: Mrs. Nora a. Jones
Address: R.D. Box 7 Fruitland Maryland

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Jan. 21-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & C. Walter P. Holloway
Address: Salisbury Maryland

19. 1/21/46 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 19th 1946 at 8:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1946, to Jan 19 1946
and that I last saw him alive on Jan 18 1946

Immediate cause of death	DURATION
Uremia Pneumonia	5 days
Due to	
Due to Influenza	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Wanner M.D.
M. D. or other
Address: Salisbury Date signed: 1/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

11654

Reg. Dist. No. 339

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: R.B. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Lincoln ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alan Decator Lamore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 29 - 1945

8. AGE: Years | Months | Days: 10 | If less than one day: ..... hrs. ..... min.

9. Birthplace: R.B. Hoyt. Salisbury Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Raymond M. Lamore

FATHER — 13. Birthplace: Bivalve Md.

MOTHER — 14. Maiden name: Beatrice Budd

MOTHER — 15. Birthplace: Machapungo Va.

16. Informant: M. Raymond M. Lamore

Address: 114 Lincoln ave. Salisbury Md

17. Buried (Burial, cremation, or removal? Which?) Date thereof: Jan. 10-46 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & C. Walter R. Holloway

Address: Salisbury Maryland

19. 1/10/46 (Date rec'd by registrar) Lassie E. Johnson (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9th 1946 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 1945 to Jan 9 1946 and that I last saw h.. alive on Jan 7 1946

Immediate cause of death	DURATION
Due to: Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Thomas A Insley M. D. or other

Address: Salisbury Md Date signed: 1/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137a)

CERTIFICATE OF DEATH

01135

Reg. Dist. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Days
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico Worc.
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: 70

3. (a) FULL NAME: Hosea Marshall

3. (b) Social Security Number: No Social Security Applied Snow Hill Md

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Bessie Marshall
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): May 1 - 1880
8. AGE: Years: 65+ Months: 8 Days: 0 If less than one day: hrs. min.
9. Birthplace: Pocomoke City, Worcester Md (Town, county, and state)
10. Usual occupation: Saler
11. Industry or business:
FATHER 12. Name: Asbury Marshall
13. Birthplace: Maryland
MOTHER 14. Maiden name: Armitta Dale
15. Birthplace: Maryland
16. Informant: Mrs Bessie Marshall
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 6 46 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill, Md
18. Funeral director: Hearne & Ramey
Address: Snow Hill, Md
19. 1/6 19 46 Hazel D. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 19 46 at 8 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 25 19 45, to 1/1 19 46 and that I last saw h[illegible] alive on 1/1 19 45

	DURATION
Immediate cause of death: Hypertrophied Prostatitis	
Due to: Hypertrophied Prostatitis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 1/8/46

Dr. Yeaman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01036

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, institution, or street address where death occurred: 209 W. Isabella ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 209 W. Isabella ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME James Frank Mason

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Lydia L. Mason
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Sept. 26-1855

8. AGE: Years: 90 | Months: 3 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Parksley Va. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:

FATHER
12. Name: Ale Mason
13. Birthplace: Parksley Va.

MOTHER
14. Maiden name: Polly
15. Birthplace: Parksley Va.

16. Informant: Mrs. Maddy Mason Culver
Address: 209 W. London ave Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 14-46 (month) (day) (year)
Cemetery or crematory: Parsons Mem.
Location: Salisbury Maryland

18. Funeral director: Hellings & Co. Walter R. Hellings
Address: Salisbury Md.

19. 1/14/46 (Date rec'd by registrar) Hassie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11. 1946 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 1946, to Jan 11, 1946 and that I last saw h.[illegible] alive on Jan 11, 1946. 19

	DURATION
Immediate cause of death: Coronary Thrombosis.	?
Due to: Arteriosclerosis.	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John H. Yeaman M.D.
M. D. or other
Address: 238 Camden Ave, Salisbury, Md. Date signed: 1/12/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01037

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 5/9/45
Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
How long in hospital or institution? since 5/9/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 147 By*Pass
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Morris, Essie A.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Welton Morris
6.(c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): Jan. 29, 1916

8. AGE: Years	Months	Days	If less than one day
29	11	7	....hrs. ....min.

9. Birthplace: Princess Anne, Maryland (Town, county, and state)
10. Usual occupation: Laundry-shirt presser
11. Industry or business
FATHER 12. Name: Harry V. Welch
13. Birthplace: Del. ~~Maryland~~ ~~Delaware~~
MOTHER 14. Maiden name: Bertha Ellison
15. Birthplace: Delaware Bridgeville
16. Informant: self & Mother Mrs. Bertha Welch
Address: 147 Elm St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 9-1946 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Co. Walter P. Holloway
Address: Salisbury, Maryland
19. 1/9/46 Received by Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1946, at 8:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 1945 to 1/6/46 1946
and that I last saw her alive on Jan. 6 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	6 weeks upon admission
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.: ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of: ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ....
Means of injury: ....Injured at work?
23. SIGNATURE: Paul Cohen M. D. or other
Address: Snow Hill, Md. Date signed: 1/7/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01038

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 days

Hospital, Institution, or street address where death occurred: Peninsula Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hebron (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lionel Marion Phillips

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Lola Wheley Phillips

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 31 1890

8. AGE: Years: 56 | Months: 11 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wicomico County, Md. (Town, county, and state)

10. Usual occupation: Mill Work

11. Industry or business: Saw Milling

FATHER — 12. Name: William S. Phillips

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Dixie Phillips

MOTHER — 15. Birthplace: Hebron Md.

16. Informant: Mrs. Helen Phillips

Address: Hebron Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 11 1946 (month) (day) (year)

Cemetery or crematory: Hebron Cem.

Location: Hebron Md.

18. Funeral director: David E. Messick

Address: Hebron Md.

19. 1/11 1946 (Date rec'd by registrar) Registrar

(Physician unable to verify age.)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 9 1946 at 4:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/21 1945 to 1/8 1946 and that I last saw him alive on 1/8 1946

Immediate cause of death	DURATION
Pneumonia	17 days
Due to: Extensive 3° Burns	17 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 12/21/45

Where did injury occur? Hebron (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: 3° Burns of body Injured at work? No

23. SIGNATURE: Chas. V. Sheridan M.D. M. D. or other

Address: Salisbury, Md. Date signed: 1/9 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (180)

01039

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 102 Oak street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md — County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Oak st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen May Godwin Primm

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 7 - 1924

8. AGE: Years 21 — Months 9 — Days 6 — If less than one day ... hrs. ... min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER
12. Name: George A. Godwin
13. Birthplace: Bishopville Md.
MOTHER
14. Maiden name: Mamie Watson
15. Birthplace: R.D. St. Martin Md.
16. Informant: Mr. Geo. A. Godwin
Address: 102 Oak st. Salisbury Md
17. Burial — Date thereof: Jan. 16-46
(Burial, cremation, or removal (Which?)) (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 1/16 1946 — [illegible] Johnson, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 13th 1946, at 6 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death: Burns of entire body — DURATION: Sudden death
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident — Date of 1/13/46
Where did injury occur? Salisbury Wicomico Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Burned — Injured at work? No

23. SIGNATURE: T. A. K. Rademaker, Deputy Med. Examiner — M. D. or other
Address: Salisbury, Md. — Date signed 1/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Kitto

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution or street address where death occurred: P.G. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 406 Oak Hill ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Dorothy Mae Purcell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 9- 1930

8. AGE:

Years	Months	Days	If less than one day
15	1	17	hrs. min.

9. Birthplace: Salisbury md.
(Town, county, and state)
10. Usual occupation: School Girl
11. Industry or business:

FATHER
12. Name: Roger W. Purcell
13. Birthplace: Salisbury md.

MOTHER
14. Maiden name: Doris N. Harrington
15. Birthplace: R.D. Salisbury md.

16. Informant: Mr. Roger W. Purcell
Address: 406 Oak Hill ave. Salisbury Md

17. Buried
(Burial, cremation, or removal: Which?)
Date thereof: Jan. 29-1946
(month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Willett R. Holloway
Address: Salisbury md.

19. 1/29/46
(Date rec'd by registrar)
Harriet J. Johnson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26 1946, at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 January 1946, to 26 Jan. 1946
and that I last saw her alive on 25 Jan. 1946

Immediate cause of death	DURATION
Encephalitis lethargica	2 days
Due to	
Due to	
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: Lumbar punctures with spinal fluid findings as above
Date of op. 1/24/46
Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. E. Kitto, M.D.
M. D. or other
Address: 321 Camden Ave. Salisbury, Md.
Date signed: 1/28/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01141

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 16 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Worcester

City or town: Bishop Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mr William Peter Quillen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Mrs. Cecil Quillen

6.(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1891

8. AGE: Years: 54 | Months: 11 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Worcester Co. Md. (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER

12. Name: William T. Quillen

13. Birthplace: Berlin

MOTHER

14. Maiden name: Mary E. Murray

15. Birthplace: Worcester Co. Md.

16. Informant: Cecil Quillen

Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14, 1946 (month) (day) (year)

Cemetery or crematory: Edgehill Cem.

Location: Pocomoke, Md.

18. Funeral director: Marguette E. Watson

Address: Pocomoke City, Md.

19. 1/14, 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 11 - 1946, at 2 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946, to Jan 11 1946, and that I last saw him alive on Jan 11 - 1946

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Louis A Insley M.D. M. D. or other

Address: Salisbury, Md. Date signed 1-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

O 1087

Reg. Dist. No. 331

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Scarborough

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Do not Know.
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Ab. 30			hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Lumber Mill
MOTHER FATHER 12. Name: George Scarborough
13. Birthplace: Virginia
MOTHER 14. Maiden name: Lillian Drummond
15. Birthplace: Virginia.
16. Informant: Annie Lee Shields.
Address: Marionville, Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14, 1946. (month) (day) (year)
Cemetery or crematory: St. Luke
Location: Daughterty Virginia
18. Funeral director: J. Edgar Thomas
Address: Accomac, Va
19. 7/14 1946 (Date rec'd by registrar) Mrs J M Vaden Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 5 1946, at 11:40 P. M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19.. to ..... 19.. and that I last saw h.. alive on ..... 19..

Immediate cause of death	DURATION
(a) Fx & wound of skull	Sudden Death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: Jan 5, 1946
Where did injury occur? Hebron (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Struck on head with axe Injured at work? No

23. SIGNATURE: J A Cadmus MD M. D. or other
Address: Salisbury Md Date signed: 7/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01042

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since 11/15/45
Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
How long in hospital or institution? Since 11/15/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #1 (Shad Point)
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Sirman, Homer J.

3.(b) Social Security Number: 217-10-3705

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Laura Sirman
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1898

8. AGE: Years	Months	Days	If less than one day
47	2	9	...hrs. ...min.

9. Birthplace: Snow Hill, Maryland (Town, county, and state)
10. Usual occupation: Sawyer
11. Industry or business
FATHER 12. Name: William M. Sirman
13. Birthplace: Salisbury, Maryland
MOTHER 14. Maiden name: Cordelia West
15. Birthplace: Snow Hill, Maryland
16. Informant: self
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7/46 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill
18. Funeral director: Hearne & Dennis
Address: Snow Hill, Md
19. 1/8 1946 Harriet L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1946, at 1:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1945, to 1/6/46 1946
and that I last saw him alive on January 6, 1946 1946

Immediate cause of death: Chronic Nephritis — DURATION: 2 mo
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D. (M. D. or other)
Address: Snow Hill, Maryland Date signed: 1/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Gramse

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

01043

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, Institution, or street address where death occurred: 511 S. Division street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 511 S. Div. St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Eli Wesley Smullen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M. Smullen
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.): May 15 1870

8. AGE: Years	Months	Days	If less than one day
75	7	23	hrs. min.

9. Birthplace Worcester Co. Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Farmer
FATHER 12. Name Elijah Henry Smullen
13. Birthplace Worcester Co. Md.
MOTHER 14. Maiden name Mary Heather Lowe
15. Birthplace Somerset Co. Md.
16. Informant M. Wandy Smullen
Address 511 S. Div St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12-46 (month) (day) (year)
Cemetery or crematory Wicomico Mem. Park
Location Salisbury Md.
18. Funeral director Hollowell & Walter R. Hollowell
Address Salisbury Md.
19. 1/12/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 8 1946 at 11 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1945, to Jan. 1946
and that I last saw h[illegible] alive on Jan 7 1946

Immediate cause of death	DURATION
Pneumonia, Bronchial, Due to Cor. P.	3 days.
Due to	
Due to	
Other conditions Arteriosclerotic Heart Disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Ferrel R. Gramse M.D. M. D. or other
Address Salisbury, Md. Date signed 1/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01044

Reg. Diat. No. 33-3

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: P. O. Box 45
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: P. O. Box 45
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Elijah Hargist Smullen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertie Ellen Smullen
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): Jan. 22nd 1877

8. AGE:

Years	Months	Days	If less than one day
68	11	18	....hrs. ....min.

9. Birthplace: Worcester Co. Md. Snow Hill (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Farmer
FATHER 12. Name: Elijah Henry Smullen
13. Birthplace: Md. Snow Hill Md.
MOTHER 14. Maiden name: Mary Frances Fokey
15. Birthplace: Somerset Co. Md.
16. Informant: Mrs. Gertie Ellen Smullen
Address: Box 45 Fruitland Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 13-46 (month) (day) (year)
Cemetery or crematory: Smullen Cem.
Location: St. Luke Worcester Co. Md.
18. Funeral director: Fillings & Co. Salisbury Md.
Address: Salisbury Md.
19. 1/13/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 10th 1946 at 2:30a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1945 to Jan 10 1946 and that I last saw him alive on Jan 1 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to:	
Due to: Hypertension	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wanner M.D.
M. D. or other
Address: Salisbury Md. Date signed: 1/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

01045

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: 301. E. Isabella street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 301. E. Isabella st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Larry James Toadvine

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertha M. Toadvine
6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Oct. 20 1885

8. AGE: Years	Months	Days	If less than one day
60	2	17	... hrs. ... min.

9. Birthplace: P.O. Salisbury Md.
(Town, county, and state)
10. Usual occupation: Owner of
11. Industry or business: Taxi Business

FATHER
12. Name: William James Toadvine
13. Birthplace: P.O. Salisbury Md

MOTHER
14. Maiden name: Clara Emily Brown
15. Birthplace: Worcester Co. Md

16. Informant: Mrs. Bertha M. Toadvine
Address: 301. E. Isabella st. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 10-1946 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Hollowayay & Co. Walter R. Holloway
Address: Salisbury Md.

19. 1/10 1946. Maggie E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 7 1946 at 4-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-7 1946, to 1-7 1946
and that I last saw h... alive on Dead on arrival 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Rivers Hanson M. D.
M. D. or other
Address: Salisbury, Md. Date signed 1/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

01046

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred: 102 Oak Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 Oak Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Tracy

3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widower
6.(b) Name of husband or wife Aritelle Tracy
6.(c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) May 4th 1890

8. AGE: Years 55 Months 8 Days 10 If less than one day ...... hrs. ...... min.

9. Birthplace Georgetown Delaware (Town, county, and state)
10. Usual occupation
11. Industry or business Farmer

FATHER
12. Name Tracy
13. Birthplace Georgetown Del.

MOTHER
14. Maiden name Rebecca Tracy
15. Birthplace Georgetown Del.

16. Informant Mrs. Eldin M. Donovan
Address R.D. #2 Frankford Del.

17. Burial Date thereof Jan. 20-46
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Dagsboro Cem.
Location Dagsboro Delaware

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland.

19. 1/20/ 1946 [signature] Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 13th 1946, at 6:15a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...... 19 ...... to ...... 19 ......
and that I last saw h ...... alive on ...... 19 ......

Medical examiner's certificate

Immediate cause of death: Burns of entire body

DURATION

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 1/13/46
Where did injury occur? Salisbury Wicomico Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury House caught fire
Injured at work? No

23. SIGNATURE [signature] Deputy Med Examiner
M. D. or other
Address Salisbury Md Date signed 1/19/46

T

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

01047

CERTIFICATE OF DEATH

Reg. Dist. No. 331

1. PLACE OF DEATH:

County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 8 years

Hospital, Institution, or street address where death occurred: Quantico Maryland

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Quantico (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mrs. Angie Tull

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	AA	widow

6.(b) Name of husband or wife: Frank Tull

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3-6-1883

8. AGE: Years	Months	Days	If less than one day
62	10	3	..... hrs. ..... min.

9. Birthplace: Chances, Somerset Co. Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Same

FATHER — 12. Name: Columbus Burns

FATHER — 13. Birthplace: Chance, Maryland

MOTHER — 14. Maiden name: Easter Dashiell

MOTHER — 15. Birthplace: White Haven, Maryland

16. Informant: Mrs. Margaret Dashiell

Address: Quantico, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-13-46 (month) (day) (year)

Cemetery or crematory: Chance Cemetery

Location: Chance, Maryland

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md

19. Jan 10 1946 (Date rec'd by registrar) Mrs J. M. Wallace Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9th 1946 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 6 1946 to Jan 9 1946 and that I last saw h... alive on Jan 9, 46. 19....

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: D Allen Tull M. D. or other

Address: Salisbury Md Date signed 1-10-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

01048 Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred: 301. E Pine Street
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 301. E. Pine (If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Aurelius Purnell Twilley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Sarah Emma Twilley
6.(c) If alive, give age ..... years Dead.
7. Birth date of deceased (mo., day, yr.) Oct. 8 2d 1862

8. AGE: Years 83 | Months 3 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace P.O. Salisbury Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business Laborer
FATHER 12. Name Robt Twilley
FATHER 13. Birthplace Wicomico Co. Md.
MOTHER 14. Maiden name Lester Legan
MOTHER 15. Birthplace Wicomico Co. Md.
18. Informant Family Record
Address R No 2 Walston Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 25-1946 (month) (day) (year)
Cemetery or crematory Wicomico Mem. Park
Location Salisbury Maryland
18. Funeral director Hillsman & Walter R. Hillsman
Address Salisbury Maryland
19. 1/25 1946 Received (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22nd 1946 at 115 P. M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1945 to Jan 22 1946
and that I last saw h... alive on Jan 19 1946
Immediate cause of death Cerebral Hemorrhage — DURATION 6 weeks
Due to Hypertension — DURATION Months
Due to ..... — DURATION .....
Other conditions Valvular Heart Disease — DURATION .....
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Howard R. Mann M. D. or other
Address Salisbury Md Date signed 1/23/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

01049

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 422 E Isabella St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frederick Edward Wagner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Ella Nora Wagner (Dead)
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 21-1867

8. AGE: Years 78 | Months 3 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: Retired Machinist

11. Industry or business

FATHER
12. Name: William Wagner
13. Birthplace: Germany

MOTHER
14. Maiden name: Regina [redacted] B. Brock
15. Birthplace: Germany

16. Informant: Mr. John Wagner
Address: Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 1/12/1946 Harriet E. Johnson Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 8th 1946, at 9:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946, to Jan 6 1946
and that I last saw h[redacted] alive on June 7 1946

	DURATION
Immediate cause of death: Chronic myocarditis	4 yrs.
Due to:	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Nature of injury: ..... Injured at work?

23. SIGNATURE: Wann M.D.
M. D. or other
Address: Salisbury Date signed 1/9/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

01050

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 10/21/43
Hospital, institution, or street address where death occurred:
Eastern Shore Tb. Sanatorium
How long in hospital or institution? Since 10/21/43

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 219 Newton Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: Waller, James

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 21, 1880

8. AGE: Years	Months	Days	If less than one day
65	1	27	hrs. min.

9. Birthplace: Somerset County, Maryland (Town, county, and state)
10. Usual occupation: Ironer - Shirt Factory
11. Industry or business:

FATHER
12. Name: Not Known
13. Birthplace:

MOTHER
14. Maiden name: Lizzie Somers
15. Birthplace: Somerset Co., Md.

16. Informant: Self
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1 / 21 / 46 (month) (day) (year)
Cemetery or crematory: Allen Methodist Cemetery
Location: Allen, Md

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md

19. 1/21/46 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1946 at 7:15 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 21 1943, to Jan. 18 1946 and that I last saw him alive on Jan 18 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	28 months
Due to: Arteriosclerosis	
Due to:	
Other conditions: Valvular heart lesion	unknown

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul [illegible] M. D. or other
Address: Snow Hill, Maryland Date signed: 1/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Only:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-m)

CERTIFICATE OF DEATH

01051

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 3 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Somerset

City or town Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war V

3.(a) FULL NAME Webster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 22, 1946

8. AGE: Years | Months | Days | If less than one day ..... hrs. 35 min.

9. Birthplace Salisbury - Maryland. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Mr. Vaughn Webster

13. Birthplace Crapies Md.

MOTHER 14. Maiden name Julia Catherine Gibson

15. Birthplace Champ.

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 1/23/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22 19 46 at 11 25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Congenital monster	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos A Finch M. D. or other

Address Salisbury Md. Date signed 1-23-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

01052

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day.
Hospital, institution, or street address where death occurred: Peninsula Gen.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Wilkerson, Levin C.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 26, 1870

8. AGE: Years 75 | Months 8 | Days 17 | If less than one day: hrs. min.

9. Birthplace: Worcester
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Peter Wilkerson
13. Birthplace: Md.

MOTHER
14. Maiden name: Nannett Bunnier.
15. Birthplace: Md

16. Informant: Katie Baker
Address: Bishop Md.

17. Burial, cremation, or removal. Which?: Burial
Date thereof: Jan. 15, 1946 (month) (day) (year)
Cemetery or crematory: Evergreen Hill
Location: Whaleyville Md.

18. Funeral director: M. Pasha Watson
Address: Selbyville, Del.

19. (Date rec'd by registrar) 1/15 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-13 1946, at 7 31 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
3rd degree burns of face chest arms & legs	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 1/12/46
Where did injury occur? Nr Whaleyville (City or town) Worcs (County) Md (State)
Injured at home, farm, industry, public place (where?): None
Means of injury: oil drum exploded Injured at work? No
nr stove
23. SIGNATURE: Deputy Med Examiner M. D. or other
Address: Salisbury, Md Date signed: 1/13/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

W. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (148-6)

CERTIFICATE OF DEATH

01053

Reg. Dist. No. 333

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Delaware County Sussex
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. R F D #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Wilkerson-Mrs. Violet

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Married

6.(b) Name of husband or wife Mr. Ernest Wilkerson
6.(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) aug 16 - 1915

8. AGE: Years	Months	Days	If less than one day
30			hrs. min.

9. Birthplace Sussex County, Del
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home.

FATHER
12. Name Leo Gullett
13. Birthplace Sussex County Del.

MOTHER
14. Maiden name Maggie Mitchell
15. Birthplace Sussex county, Delaware.

16. Informant Ernest Wilkerson
Address Delmar Del

17. Burial (Burial, ~~cremation~~, or Removal, Which?) Date thereof 1-10-46 (month) (day) (year)
Cemetery or crematory Pine
Location Whitesville, Del

18. Funeral director W.S Harvel Co
Address Delmar, Delaware

19. 1/10 19 46 Received by me (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 8 19 46, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 19 45, to Jan 8 19 46
and that I last saw h... alive on Jan 8 19 46

Immediate cause of death	DURATION
acute nephritis	12 days
acute hepatitis	"
Due to	
Due to	
Other conditions Abortion - 3 mo preg	8 days
acute oedema of glottis	

(Include pregnancy within 3 months of death)

Major findings of operations None
Tracheotomy Date of op. 1/5/46
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Rademaker M. D. or other
Address Salisbury, Md Date signed 1/8/46

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. 100 FEB 26 1946

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Va County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Vesta Elizabeth Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Lilleton J Williams
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 19 1860

8. AGE: Years	Months	Days	If less than one day
86 85	9	2	hrs. min.

9. Birthplace: Chincoteague Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Richard Carpenter
13. Birthplace: Chincoteague Va

MOTHER
14. Maiden name: Mary Lewis
15. Birthplace: Chincoteague Va

16. Informant: Marvin Williams
Address: Chincoteague Va

17. Burial (Burial, cremation or removal. Which?) Date thereof Jan 25 1946 (month) (day) (year)
Cemetery or crematory: Mechanics Chincoteague Va
Location: Chincoteague Va

18. Funeral director: Walter M. Lelarks
Address: Chincoteague Va

19. 1/26 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 1946, at 12:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Medical Examiner 19 to 19
and that I last saw h alive on 19
Immediate cause of death: Coxalgia

	DURATION
Fractured Hip	3½ mos
Due to	
Due to	
Other conditions: Pneumonia, Senility	2 days unknown

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 11/4/45
Where did injury occur? Chincoteague (City or town) Accomac (County) Va (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: fell in bathtub Injured at work? No

23. SIGNATURE: Lokadamer Deputy Med Exam M. D. or other
Address: Salisbury Md Date signed 1/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15